ASSOCIATION NOTES

REPORT ON MEDICAL SERVICES INSURANCE IN AUSTRALIA

Your observers spent approximately three and one-half weeks in Australia visiting four of the six states, and Canberra, the capital city. It is our intention to illustrate in this report factors of significant and general interest in the development of the Australian system of health services insurance.

We have found it impossible to restrict our comments to medical services insurance. A broad understanding of the organization of hospitals and medical services is necessary in order to measure the success of the insurance method which the Australian people have chosen and to determine the degree of its acceptance by the profession and the public. This report will be general in nature and will not attempt to describe the details of the various measures adopted.

Australia and Australians

Australia and Canada are similar in many ways. Both countries have unfavourable climatic conditions—many parts of Australia are very hot, as many parts of Canada are very cold. In each instance, this results in a low population density. In Australia about a third of the continent is almost uninhabitable and in another third the rainfall is too low to permit close settlement. Thus, like Canada, the largest part of the population is concentrated in one geographic area.

Economically, Australia and Canada have many similarities. Australia has large potential wealth-producing areas which are not developed. Like Canada, foreign capital will probably be necessary for large-scale development. Both countries are dependent upon the income produced from the export of basic commodities, and to help counter an unfavourable balance of imports over exports both countries recognize the need for developing secondary industry.

Post-war inflation has been a problem in Australia as in Canada, and in Australia the effects have assumed more serious proportions. Today, Australia like Canada is re-examining its economic policies to allow for a more orderly development of its resources without the ever-present fear of inflation.

Australians are predominantly of British descent and they are still oriented towards Great Britain in many ways. However, since the war immigration has brought into the country a number of new Australians—a great number from Central and Southern Europe. These immigrants have brought new traditions to Australia, including new concepts of the relationship of the individual towards group organizations such as government, the medical profession and the union movement.

The typical Australian has developed certain characteristics which are perhaps due to the inhospitable nature of the land on which he lives. He has an individualistic spirit with a much more ready acceptance of personal responsibility than the typical Canadian. He has, as well, a sense of interdependence which we have seen in the ready acceptance of group leadership. These two characteristics introduce a curious paradox of individuality and conformity—the typical Australian, while strongly individualistic, is nonetheless determined not to be a "blackleg".

The Australian doctor retains a strong British tradition. The consultant or specialist, in most instances, has taken his postgraduate study in Britain and readily accepts the closed hospital system. All doctors have retained a high professional status in the community, and while their incomes are lower than that of the average Canadian doctor, they are higher in proportion to income of other members of the community.

Outline of Medical and Hospital Organization

Australia has a federal governmental system. A written constitution determines authority and responsibility as between the Commonwealth government and the various state governments. The residual power remains with the states rather than with the federal authority, which is in contrast to the Canadian system.

Health is a state, not a federal, responsibility. Hospitals and medical services are controlled by state authorities.

The hospitals may be classified as private and public. The private hospital receives a small subsidy from public funds but basically relies upon patient payments for its income. The larger private hospitals are run by religious institutions. Smaller hospitals may be operated for profit. Very few are owned by doctors. The equipment and services in these hospitals may be very limited, and in some instances patients have to be taken to public hospitals or to private offices by ambulance for special investigations.

Public hospitals are substantially subsidized by state governments. Patient payments account for slightly more than one-half of hospital revenues. Budgets are closely controlled by state hospital commissions. Although nominal management of each hospital rests with the hospital board, often financial control is used by the state hospital authority to institute a rigid control over all hospital matters. In terms of equipment and services, these hospitals are comparable to our general hospitals.

All beds in private hospitals are private beds, available to all doctors in the community. Physicians may admit and treat their patients without the supervision of an organized medical staff.

In public hospitals medical care is provided by an intern and resident staff supplemented by a supervisory honorary staff, usually composed of consultant or specialist doctors. In smaller hospitals general practitioners may be appointed to the honorary staff. The number of doctors in each category is determined for each hospital by the state hospital commission. Thus, there is a closed medical staff, the number of which is determined by an outside authority. The intern and resident staff are on salary to the hospital and the honorary attending staff provides its services gratuitously. Thus in "public" beds the patient does not pay for his physician's services. More than one-half of all hospital beds in Australia have been designated as "public" beds. The honorary system substantially reduces the cost of medical services and indirectly subsidizes medical benefit insurance plans.

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Many public hospitals provide "intermediate" as well as "public" beds. The cost of hospitalization in "intermediate" beds is subsidized to a lesser extent from public funds. The patient pays the full cost of his physician's services and he is entitled to the rights and privileges of a private patient. The number of intermediate beds is small in proportion to the number of public beds. Although in theory these beds are available to all practitioners, they are much more accessible to members of the honorary staff. The profession would like to see the number of intermediate beds increased but the hospitals' commissions have not agreed, as their attitudes are determined by the political philosophies of their state governments.

In one state, Queensland, all members of the honorary staff are paid by the hospital on a sessional or half-day basis. Medical services are of course provided without charge to all patients in "public" beds. In Queensland any person may obtain hospitalization without charge by asking to be admitted to a "public" bed. In other states admission to a "public" bed is allowed only on the basis of an income qualification and the patient's hospitalization is partially subsidized by the state but is not provided free.

In all states it is usual for the pathologist and the radiologist to be salaried employees of their hospitals. Recently, a trend has developed to employ physicians and surgeons on a full-time or part-time basis, initially for special services such as thoracic surgery and cardiac surgery, but more recently to provide more general services. In some instances, these doctors are replacing members of the honorary attending staff.

Full-time employment appears to be viewed with approval by the hospital commissions. It is used to provide medical services in localities which cannot support a doctor. It is also used to provide specialist services, particularly surgical, in areas where these specialist skills are not represented. The ultimate in this trend can be seen in certain hospitals wherein all medical services are performed by full-time salaried doctors.

These full-time posts can be filled because some younger specialists, unable to find financial security in private practice, are turning to salaried hospital employment. These specialists are increasing as the number of younger men with higher qualifications exceeds the requirements of the honorary system. As such a large part of in-hospital practice is public, and therefore non-remunerative, and the remainder largely utilized by the senior honorary consultants, private practice is difficult for the young specialist to obtain.

A large segment of the profession wishes to retain the honorary system because of tradition and to avoid an employer-employee status in the treatment of public patients. Honorary appointments are much sought after. They provide the means by which contact is made with the referring doctor who subsequently may refer private patients as well as public patients. Thus the kudos of the honorary system is important financially to the consultant.

General practitioners have very limited access to hospitals for the treatment of their patients. Patients in public beds are treated by "honoraries", and the general practitioner's privilege of using intermediate beds is more apparent than real except in rural areas.

General practitioners can treat their patients in private hospitals. The number of these beds varies with the locality. The variety and amount of work done is affected by the availability of free treatment in public hospitals.

ORGANIZATION OF PRACTICE IN DOCTORS' OFFICES

The organization of practice is similar to that in Canada. There is an increasing tendency to form small group practices composed mainly of general practitioners. In some suburban practices, a young physician or surgeon may be associated with the group. Many general practitioners in solo practice still work from their homes although some are now setting up practice in a separate office. Office overhead is variable and as a proportion of gross income is similar to Canadian experience.

The average general practitioner sees more patients in a day than his Canadian counterpart. We have seen some solo general practices in which 80 or 90 patients are treated in a normal day. Our impression is that in the average practice 40 to 50 patients are treated each day. Very few of these patients are seen in hospitals.

The consulting rooms of specialists are concentrated in traditional areas. Each city has its own "Harley Street". There is no specialist registration and the address often confers the status of specialism. Many of these consultants also work in a suburban office where they may practise as consultants or as general practitioners.

The work load of consultants varies widely. The younger consultant sees few private patients although he will perform many services in the public hospitals. Senior consultants do almost all the private work as well as supervising the work of the resident staff in the public hospitals.

HEALTH INSURANCE IN AUSTRALIA

In the immediate post-war period, health insurance was a lively topic of interest to all Australians. The Beveridge Report was closely scrutinized by the profession and by members of government health departments. A team of British experts was invited to visit Australia to discuss the implications of this report as it related to Australia.

During the latter stages of the Second World War, a Labour Government unsuccessfully tried to introduce a pharmaceutical benefits act, which was declared *ultra vires* by the courts.

In 1946 the Chifley Government obtained by referendum an amendment to the constitution to permit the Commonwealth Government:

> "The provision of maternity allowances, widows' pensions, child endowments; unemployment, pharmaceutical, sickness and hospital benefits; medical and dental services (but not so as to authorize any form of civil conscription), benefits to students and family allowances."

In 1948 a second pharmaceutical benefits act was negated by the profession, which refused to limit prescriptions to an official list of drugs. In 1949 this act was amended to prohibit physicians from prescribing any drug listed in the government formulary other than on government prescription forms. This amendment was declared *ultra vires*, as the courts ruled that the coercion involved in its enactment entailed civil conscription. A general election shortly followed the court decision and the Labour Government was defeated at the polls.

After the election, Sir Earle Page became the Minister of Health. He introduced a system of Commonwealth benefits. The philosophy of his government was to introduce measures designed to help those people who, through participation in an insurance arrangement, had undertaken to help themselves.

MEDICAL BENEFITS

Prior to 1949, Australians obtained medical insurance through a variety of friendly societies. Medical care was usually arranged on a contract basis. In 1949, the British Medical Association (Australia) announced that it considered contract practice to be unethical. As a result of this pronouncement, the friendly societies arranged to make payment to doctors on a fee-for-service basis.

This same year, the medical profession began to organize medical benefit societies to provide medical prepayment for the general public. These were set up as non-profit plans with members of the profession and prominent lay members of the community giving their services as board and executive committee members without remuneration.

The Commonwealth Medical Benefits scheme was introduced in 1951. It operates on the principle of Commonwealth support of voluntary insurance. Eighty-three non-profit organizations have been registered with the Commonwealth Department of Health and are authorized to pay Commonwealth benefits in addition to their own medical fund benefits.

Registered organizations generally reimburse their members by cash payments. The contributor obtains medical attention from the doctor of his choice and pays the doctor's account. He then claims from his organization, payment of the Commonwealth and fund benefits to which he is entitled.

The benefit to be paid by any fund for a particular service must at least match that which the Commonwealth has agreed to pay, as listed in a schedule under the National Health Act. This is a listing of all medical services with the scheduled Commonwealth benefit listed for each service. In practice, the funds usually pay more (166⅔%) than the Commonwealth benefit, thus making membership in the fund more attractive. Combined Commonwealth and fund benefits range from 12s. to 16s. for an office or home consultation, from £8.5.0 to £12.0.0 for obstetrics and from £33.15.0 to £60.0.0 for certain major operations. The variation in the total amount of reimbursement occurs because the fund benefits will vary, depending upon the rate of premium paid. The Commonwealth benefit does not vary. On the average, these combined benefits represent approximately 65% of the total medical bill.

The weekly cost of participation in a medical benefits fund ranges from 1 shilling and threepence to 2 shillings for a single person and between 2 shillings and sixpence and 4 shillings for families, according to the level of fund benefit desired.

The medical service must be rendered by or directly on behalf of a medical practitioner. Some organizations pay fund benefits for physiotherapy, home nursing and the provision of glasses, but expenses for these services are not eligible for Commonwealth benefits.

The combined Commonwealth and fund benefit cannot exceed 90% of the doctor's account.

In cases of genuine need, the doctor can waive the direct payment to be made by the patient. Under these circumstances, the fund makes the benefit cheque payable to the doctor but forwards it to the patient. Likewise, when the patient is faced with a large medical bill which he cannot pay from his own resources, he may ask that the fund benefit cheque be made payable to the doctor, and subsequently pay the remainder of his account. The cheque is forwarded to the patient. In the largest medical benefit fund in Australia, 16% to 19% of all accounts are paid in this fashion. The procedure is closely watched in order to ensure that abuses of the system do not arise.

New members of an organization must serve a waiting period before benefits become payable. The length of the waiting period varies according to the rules of the organization, but is generally—(a) accidents —nil; (b) all services except obstetrics—two months; (c) obstetrics—10 months. The Commonwealth benefit is subject to a two-month waiting period for new members.

Should contributions fall into arrears, benefit is not payable. The Commonwealth benefit may, however, be paid in these cases if, on the date the medical service was rendered, the contributor was receiving unemployment or sickness benefits under the Commonwealth Social Services Act.

Life insurance and friendly society medical examinations are not eligible for benefits.

Eye examinations as a result of which glasses are prescribed are not eligible for Commonwealth benefits. However, fund benefits are sometimes payable in these cases.

The Commonwealth benefit is payable for pathological and radiological services and electroencephalograms received from a public hospital. Otherwise, charges by a public hospital for medical attention generally do not qualify for benefit.

Repatriation (D.V.A.), third party liability, workmen's compensation and similar cases are generally excluded from Commonwealth and fund benefits because the expense of the medical treatment is not borne by the member.

Until recently, rules of the benefit organizations provided for disallowance of claims in cases of pre-existing ailments and long-term illnesses. Special provision is now made for both fund benefit and Commonwealth benefit to be paid in these cases. These benefits are paid from special accounts which the government guarantees.

These special accounts have been set up by all major medical benefit societies. The fund managers may place in these special accounts any contributor who has a pre-existing disability. Persons over the age of 65 who join a medical benefits fund may be placed in this special account section. As well, participants are transferred to the special account when their medical claims exceed the maximum benefits provided by the fund. Each organization is required to notify the department and to specify the grounds upon which each transfer to the special account is made.

All other members of the contributor's family must be placed in the special account as well, together with the premium paid on their behalf. Once a contributor is placed in this special account, he must remain therein for a period of at least two years. This qualification is set out in order to act as a brake on fund management on over-use of these special accounts.

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The fund may not derive any reserve funds from the premiums of these special account contributors and thus it is in the interest of fund managers to use these special accounts with discretion. If a participant is not placed in the special account, the fund must pay benefits from its ordinary account for all services required including services for pre-existing disabilities.

In 1960, 72% of the population was covered by medical benefit schemes, and Commonwealth expenditure on medical benefits was more than £9 million.

ACCEPTANCE BY THE PUBLIC

In 1953, 16% of the population was enrolled in medical benefit funds. In 1960, 72% of the population was covered for benefits. This would indicate that the public has accepted this arrangement very well. In talking to members of the public, it was obvious that they considered that for the premium charged the benefits derived were satisfactory. The only persons we met who considered the scheme unsatisfactory were officials of the labour movement.

Of the 28% of the population which was not insured for medical benefits in 1960, 7% received services under the Pensioners' Medical Service and 7% received services under the Repatriation Department (D.V.A.); thus only 14% of the population was not insured. These were people living in sparsely populated rural areas, people in high income brackets who could claim the full amount of medical expenses as an income tax deduction and thus were less likely to require medical insurance, persons whose membership had lapsed because of changing employment, a group of persons who did not agree with health insurance for religious or other reasons, and finally the irresponsible element of the community known in Australia as the "no hopers".

While the public is satisfied with the level of benefits paid for services such as office consultations, they consider that the benefits for some of the more expensive procedures are too small. This concern would be much more serious except that many members of the public can elect to receive in-hospital medical services in a "public" bed and thus incur no medical expenses whatsoever. For very expensive medical procedures such as cardiac surgery, it is obvious that the income qualification for public beds is being waived.

The average private patient is the one most concerned with the difference between the amount of total benefits and the doctor's fee. Although many doctors acquaint their patients in advance of the amount of their fees, there are no published fee schedules and in some instances the patient may receive an account which is substantially in excess of the total benefits for which he is reimbursed.

This arises because the Commonwealth schedule of stated benefits for each service, once set up, is very difficult to amend, as all funds have to agree to increase the fund benefit proportionately, and treasury approval has to be obtained. Since 1951 there has been only one major re-negotiation of benefits, which was restricted largely to services which occur infrequently. Because the Commonwealth benefit has been relatively fixed since 1951, it has been difficult for doctors to increase their fees, even though the country has experienced a substantial degree of inflation, because the patient himself has to pay the full amount of any increase in fees.

In the past, the medical benefit societies have increased their fund benefits in order to keep the patient's direct payment to the doctor at about the same percentage (36%).

Recently, it was necessary for the funds to increase premiums to accomplish this. The Commonwealth benefit as a proportion of the total cost of medical services has steadily decreased.

Year	Fund Benefits: % of Total Cost	Commonwealth Benefits: % of Total Cost	Direct Patient Payment: % of Total Cost
1954	31.7%	31.7%	36.6%
1960	35.4%	28.2%	36.4%

One of the measures of acceptance of any health insurance program is the degree of participation in private insurance programs additional to the basic benefit structure. In Australia, this participation is minimal, comprising only 60,000 persons, mostly in closed organizations. This contrasts strongly with the British experience.

ACCEPTANCE BY THE PROFESSION

The plan is well accepted by general practitioners. As they do not, in most instances, provide free services in hospitals, they are now paid for each and every service which they render. One of the few increases which have been negotiated raised the fund benefit for office and house consultations. There does not seem to be any problem in collecting the full amount of the fee for these general practitioners' services. For all practical purposes GP's have few or no bad debts.

The general practitioner appreciates the fact that his relationship with his patient has not changed. He accepts his exclusion from the hospitals more readily than does his Canadian counterpart. His main hospital contact is with the private hospitals, especially for his maternity work.

The views of the consultants are varied. All consultants feel that they are subsidizing the scheme by the amount of their free in-hospital work. The B.M.A. has requested that doctors be allowed to charge insured patients who occupy public beds.

All consultants are acutely aware that the total of the Commonwealth benefit plus the fund benefit in large measure determines the amount of the fees which they can charge. The young consultant charges little more than the combined benefits for many services. Competition and the desire to perpetuate the scheme are major factors in this decision.

The senior consultant benefits financially from the medical benefits scheme. Some bad debts are present but this does not seem to be a particular problem. Most senior consultants feel that they should charge a higher fee to their private patients because of their skill and experience. In this respect they differ from their younger consultant colleagues, who are concerned lest the higher amounts which the patient must pay directly will cause public dissatisfaction with the scheme.

From the standpoint of the consultant, the benefits of the medical insurance program cannot be dissociated from his view of the honorary system. The young consultant feels that the honorary system is putting

a heavy financial burden upon him by consuming a good proportion of his time without payment. The advantages which he might subsequently obtain may be a decade away. He is torn between the prestige of the honorary system and the loss of freedom involved in accepting sessional or salary payments.

Some young specialists are joining groups, doing some general practice. They are doing better financially although the likelihood of their obtaining a senior appointment is less.

The senior consultant likes the honorary system. He is at the stage where the volume of private referrals compensates for the free work done, and he has no wish to become a hospital employee.

ACCEPTANCE BY THE GOVERNMENT

The Commonwealth Government is well pleased with the scheme. Although the rate of utilization of services is increasing, they attribute this to increased availability of medical care, improved health education and scientific advances. The increasing cost is accepted and abuse is considered minimal. It was interesting to us that none of the senior government administrators felt that there was any need to make major changes.

It was our impression that the party in power was gratified with the success of the plan. Even the Labour opposition finds little to criticize. It is obvious that the scheme represents an excellent method for the distribution of Commonwealth funds without infringing on states' rights. Government administration costs have been kept extremely low—only 16 people are employed to administer both hospital and medical benefit schemes at Canberra and a minimal number (150) through various centres around the country.

PENSIONERS' MEDICAL SERVICE

In 1951 the Government introduced the Pensioners' Medical Service which provides free general practitioner medical attention for all eligible pensioners and their dependents, who qualify on a means test basis.

The profession accepts a direct payment from a government department at a concessional rate of approximately 50% of their usual fees, for services which they perform in their office or in the patient's home. No provision is made for in-hospital services, as it is expected that the recipients will occupy a public bed. In addition to payment for house calls, doctors are paid mileage charges for travel in excess of two miles in the country and three miles in the city. This results in certain geographical restrictions in relation to the freedom of choice of doctor.

Under normal circumstances, there is complete freedom of choice of doctor, provided that he has indicated to the Commonwealth Department of Health that he is willing to treat pensioners. The doctor is given books in which he lists details of services provided. The patient must sign the voucher on the occasion of each visit before the doctor can be paid.

In the year 1959-60 there were 740,000 enrolled pensioners and dependents and payment of slightly more than £4,100,000 was made to 5685 participating doctors.

It is obvious that this arrangement is well accepted by the recipients. The profession, although concerned with lack of control over patients' utilization of services, is nonetheless reasonably happy with the program, as it provides at least a partial payment for a group of people to which services were previously provided without fee.

Special boards of inquiry composed of members of the profession have been set up to question any possible abuse. Relatively few cases have arisen which require this judicial function. In cases in which these boards of inquiry have found a doctor guilty of abuse of the scheme, they have imposed severe penalties. It is felt in Australia that the abuses which have arisen in connection with the pensioners' medical service can be attributed largely to the lack of financial participation by the patient. It is also considered that the severe disciplinary action, including temporary loss of licence, which the boards of inquiry have taken, have curbed appreciably the amount of abuse.

PHARMACEUTICAL BENEFITS

We have previously noted that the attempts of the Chifley Labour Government to set up a pharmaceutical benefit scheme failed. In 1950 Sir Earle Page introduced a new program which did not include the restrictive measures entailed in the previous legislation. This program provided free to all patients a range of "costly, life-saving and disease-preventing drugs", the whole cost being met by the Commonwealth Government.

Costs increased alarmingly and threatened to dominate the whole national health plan. In 1952 the cost was £7.6 million. In 1957 it was £11.7 million. In 1959 the cost had risen to £20.7 million. As a result, in March 1960 a charge of 5 shillings per prescription was imposed except for pensioners. As well, the list of drugs was expanded, so that today 70 to 80% of all prescriptions written by doctors qualify for pharmaceutical benefits.

The 5 shilling charge was applied as a brake on costs and with the further thought that to apply a charge, even though only a nominal one, would be in line with the principle of self-help, which underlies all the government's national health planning.

The public reaction to the 5 shilling surcharge is mixed. Some people resent paying for something which previously had been free. Others consider that 5 shillings is a reasonable amount to pay for prescriptions which might otherwise cost £5 or £10.

The profession feels that there is now some pressure on them to prescribe only those medications which qualify for pharmaceutical benefits. They are also concerned with the anomalies and omissions in the pharmaceutical list and the correctness of the approved indications. In order for a repeat prescription to qualify for benefit, the doctor must in the first instance have prescribed the maximum listed amount. This puts pressure on the doctor to order more than he might consider necessary.

OTHER BENEFITS

There are additional Commonwealth benefits available which do not materially affect the medical benefit system and therefore are not considered in detail in this report.

These include Tuberculosis Benefits, Workmen's Compensation and the Repatriation Service (D.V.A.). It may be of interest to note that Workmen's Compensation is similar to arrangements in the U.S.A., and the repatriation scheme is very similar to our Canadian Department of Veterans Affairs.

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OBSERVATIONS

1. *Reimbursement Method of Payment*

The reimbursement method of payment was originally introduced to maintain a direct doctor-patient relationship and to act as a brake on the over-utilization of services. It was considered that a direct financial relationship between the doctor and his patient was necessary to maintain a good doctor-patient relationship and to allow latitude to the doctor to charge a fee commensurate with the work involved and the patient's circumstances.

There is no doubt that a good doctor-patient relationship has been maintained under this system. However, the expected latitude in fees has not developed. The rigid structure of the benefits system has tended to impose a reasonably rigid scale of fees which is not as high as is consistent with the inflation in the general economy. There is no mechanism provided to allow periodic adjustments in benefits.

The reimbursement method of payment has acted as a brake on over-utilization. During the period 1958 to 1960 utilization in the pensioners' medical service (a direct payment from government to doctors) increased by 6.5% per year. Utilization in the medical benefit scheme increased by 2% per year during the same period. (While this period of comparison is short, these are the only statistics available.)

Australians consider that advantages accruing from the reimbursement system more than offset the additional administrative costs which result from processing and paying many individual claims rather than grouping the claims for each physician.

2. *Variety of Methods of Insurance*

When Sir Earle Page was introducing the program he deliberately utilized existing agencies. He stipulated that they must be non-profit in nature, be approved and registered by the Commonwealth Department of Health, and accept a reasonable amount of control and direction by the department.

The diversity of membership and function of the various agencies, particularly the friendly societies, led to a demand for varying levels of benefits. This resulted in a variable fund benefit although the Commonwealth benefit remained constant. It is interesting to note that the majority of participants prefer to join the plan which provides the maximum benefits.

We believe that the utilizing of these various agencies provides more freedom of choice and flexibility for participants and avoids the rigid monopolistic character of a single governmental agency.

3. *Commonwealth Government Participation*

In Australia, as in Canada, the Federal Government is the major taxing authority and therefore has greater access to the amounts of money needed to support a scheme which necessarily increases in cost year by year.

As we noticed an increasing trend to control of doctors and medical practice by the authorities in the various states, we appreciated the wisdom of channelling control of medical benefits through a Commonwealth rather than a state agency.

State authorities already control hospital construction and equipment, have the major say in hospital staffing both medical and lay, and are not free of political pressures in making these decisions. The state authorities have complete control over hospital budgets and in some instances reduce these budgets to match the amount of money available. This budget-paring affects the quality of the service available.

If in addition to these powers and the power to license doctors, the state authorities were also provided with some economic control over doctors through the medical benefit scheme, conditions could become very difficult for medical practitioners.

4. *The Effect of the Buoyant Economy*

The general level of prosperity existing at this time throughout Australia has obviously contributed to the acceptance of this program by the public. Because of the financial contribution from the Commonwealth Government and the subsidization of medical costs by the free work done under the honorary system, the premium is so low that it is no hardship for anyone to join. This explains the high percentage of coverage on a voluntary basis.

During the past few years unemployment has presented no problem in Australia. If, however, a recession occurs it may be reflected in a reduction in the number of people able to afford the premium. There might also be increased public dissatisfaction with the relatively high proportion of the medical care costs which the patient must pay directly, over and above the fund benefit. However, the doctor would be in a position to alleviate these costs when the patient's financial situation so indicated.

5. *The Effect of the Scheme on the Quality of Care*

This is very difficult to judge accurately on the basis of such a short study. We consider that the quality of both general practitioner and specialist care is good.

Some of the senior practitioners are concerned with the large number of patients seen by some general practitioners. Their fear is that this will ultimately result in a lower standard of medical practice. However, in our observations, some of these busy practitioners were doing work of a high calibre albeit at the expense of very long working hours and an inability to participate in postgraduate programs or in hospital organization.

The fact that general practitioners are forced to work in unsupervised private hospitals is an unsatisfactory arrangement. It could easily lead to poor-quality practice.

In some areas consultant services have been provided to assist general practitioners in rural practice, with good results as is seen in the maternal mortality statistics.

The top Australian consultants are considered among the best in the world. The best men appear to be seeking honorary appointments and the aspirants to consultant ranks are well trained, in many cases with additional training in Britain and America. These men are providing the bulk of the free services through the honorary system.

In some closed salaried hospitals the specialists do not have the same experience or qualifications as other members of the profession who are excluded from the hospital. This tendency towards full-time staffing of hospitals may eventually reduce the general standard of care as they are not always attracting the best qualified consultants.

We were pleased to find that the intellectual level of students attracted to medicine was high. There is keen competition for vacancies in the medical schools. In Australia, doctors' sons are being attracted to medicine as a career.

6. *Subsidization of Medical Costs by the Honorary System*

The value of the honorary work performed by the profession is many millions of pounds annually. This burden falls largely upon the shoulders of the consultants who, by providing free care to many insured persons, reduce the premiums which are charged to participants. The amount of this subsidy has been estimated as high as £20 million a year.

The young specialist is experiencing financial hardship as a result of this free work and is therefore more ready to seek salaried employment. However, increasing the numbers in the salaried service will decrease the number of honorary posts available and thus still further reduce the opportunities of the young specialist to enter private practice. This diminishes specialist competition and curtails the availability of in-hospital experience to the profession. It could ultimately lead to a complete in-hospital salaried service.

A possible solution of this problem would be the reclassification of a large number of public beds as private beds, in public hospitals. This would make the public hospitals very similar to the general hospitals we know in Canada. It would result in a decrease in the amount of free work done, and the increased cost to the medical benefit schemes would reflect a more realistic cost structure. We were concerned with the apparent inability of the profession and state governments to solve this problem which could lead to the downfall of the honorary system.

7. *Control of Hospitals by State Authorities*

We have mentioned the complete control which the state hospital commissions exercise over all phases of hospital operations. This control extends even to the appointment of hospital governing boards, the personnel of which is likely to change if the government changes.

It is most disturbing to note that this financial stranglehold resulted under an administrative system which is not dissimilar to that which pertains in Canadian provinces. The chief factors have been the relatively limited taxing power of the states and the need for money to develop other public services. The step between providing the funds necessary to meet the requirements of a service, and determining that level of service which can be provided within a fixed budget, is a short one. The second step involves complete control of all hospitals by the state, in fact, if not in theory.

8. *Absence of Fee Schedules*

There are no fee schedules in Australia such as we know in Canada. There are gentlemen's agreements as to the fees charged for office and house visits and to some extent for specialist consultations. Other fees have been left to the discretion of the individual medical practitioner. The absence of a fee schedule has allowed the Commonwealth benefit schedule to assume too great an importance in the determination of fees. The rigidity of the Commonwealth benefit schedule during a decade of continuous inflation is anomalous. We have concluded that government contributions determined as a proportion of premium or of cost would be a much more preferable method. The difficulty of re-negotiating fixed benefits with government is as apparent in Australia as it is in Canada.

CONCLUSIONS

The medical benefits scheme in Australia appears to be working very satisfactorily. Medical and hospital organization is so different from the Canadian pattern that it would be impossible to say that an identical system would necessarily work in Canada. However, the basic principles of their medical services insurance plan appear to be sound.

We wish to thank the British Medical Association (Australia), the doctors whom we met, the members of the public whom we interviewed, members of government and their officials and the trade union representatives for their kind co-operation and generous hospitality.

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Dr. T. J. Quintin	Dr. E. C. McCoy
Mr. B. E. Freamo	Dr. Peter Banks

PAGES OUT OF THE PAST: FROM THE JOURNAL OF FIFTY YEARS AGO

ACADEMY OF MEDICINE, TORONTO

The regular meeting of the Academy of Medicine, Toronto, was held Tuesday, February 7. The speaker of the evening was Dr. Harvey Cushing, of Johns Hopkins. The subject of his paper, "Brain Tumours and their Surgical Treatment", was based on the results obtained in some two hundred cases treated in the Johns Hopkins Hospital in the past eleven years. To show the rapid advance made in recent years, Dr. Cushing stated that eighty-two of these had been treated in the last twelve months. The main portion of the address was divided into the three headings: (1) what the tumour does; (2) what it is; and (3) how it has been treated surgically.

The pressure symptoms, Dr. Cushing said, were the most important for early diagnosis, and the local symptoms were the most useful for the localization of the tumour. The lecturer dwelt only for a moment on the cardinal symptoms of headache and vomiting. Optic atrophy, he pointed out, was not a true neuritis, but was due to pressure under the optic nerve sheath and retina. If this pressure were relieved early in the disease, before there was infiltration and fibrosis, the condition cleared up rapidly.—*Canadian Medical Association Journal*, 1: 383, April 1911.

Canad. M. A. J.
April 29, 1961, vol. 84

THE NINETY-FOURTH ANNUAL MEETING: CALLING ALL DOCTORS' WIVES

Mrs. G. W. Halpenny, Chairman of the Ladies' Committee of the Canadian Medical Association for the 94th Annual Meeting, to be held in Montreal, June 19-23, 1961, and her Co-Chairman, Mrs. N. J. Belliveau, gathered a large number of their committee together recently at the Montreal Badminton and Squash Club for the purpose of mailing a letter to the wife of every C.M.A. member in Montreal. This letter outlined the entertainment program and asked for the help of Montreal doctors' wives to make the June meeting a successful and memorable one for the visitors. Mrs. Halpenny also said in her letter that at least five hundred doctors' wives from across Canada are expected and that the success of the meeting, the first to be held in Montreal in ten years, will depend upon a large attendance of Montreal members to make the visitors feel truly welcome. A large number of volunteers will be needed each day to be present at the hospitality centre. The following committee chairmen will welcome offers of help:

Registration Mrs. H. S. Morton and Mrs. Roger Lapointe

Entertainment Mrs. S. A. MacDonald and Mrs. Paul Robert

Hospitality Mrs. George Strean, Mrs. Léon Gérin-Lajoie, Mrs. Earle Wight and Mrs. Jean-Louis Leger

Shopping Mrs. Gordon Young and Mrs. Jacques Bruneau.

Golf Mrs. C. Miller Ballem and Mrs. Gaetan Jarry

Transportation Mrs. E. A. Stewart Reid and Mrs. Jacques Genest

The plans for entertainment include a wine-tasting supper party on Monday evening; the Quebec Division of C.M.A. dinner to General Council on Tuesday evening; a ladies' luncheon at the Museum of Fine Arts on Wednesday and the inauguration of the incoming President on Wednesday evening when Dr. and Mrs. Halpenny look forward to meeting every doctor and his wife (or her husband). A highlight of the ladies' program will be a luncheon on Thursday when the guest speaker will be Mrs. William Mackersie, President of the Women's Auxiliary of the American Medical Association. A fashion show will be presented by courtesy of the Quebec Association of Furriers. In the evening the Mayor of Montreal will hold a reception at the Chalet on top of Mount Royal for all doctors and their wives attending the meeting. On Friday the ladies are invited to attend the sessions on Medical Economics when Dr. Wilder Penfield will address the meeting.

These are the plans so far, but all the details have not yet been planned and further news will appear in subsequent issues of the Journal.

MARY WEIL

Posen, Montreal

Dr. G. W. Halpenny, President-elect of the Canadian Medical Association, watches the Ladies' Committee get 1400 letters ready for mailing to Montreal doctors' wives asking for their help at the time of the meeting. Standing at left and seated left centre of table are Mrs. G. W. Halpenny and Mrs. N. J. Belliveau, Co-Chairmen of the Ladies' Committee.

PHYSICIANS' ART SALON INVITES EXHIBITORS

JUNE 20 - 23, MONTREAL

Canadian physicians and medical undergraduates with art or photographic hobbies are cordially invited to enter and compete for awards in the Physicians' Art Salon to be held in the Queen Elizabeth Hotel, Montreal, from June 20 to 23. Again sponsored by the Canadian pharmaceutical firm, Frank W. Horner Limited, the Physicians' Art Salon will mark its 17th year as a popular feature at the C.M.A. Annual Meeting.

Conditions of Entry

Entries will be accepted in three sections: (1) Fine Art; (2) Monochrome Photography; (3) Colour Photography.

The Fine Art section is further subdivided into three categories—Traditional, Contemporary (Modern) and Portrait. Classification into these categories is done by the judges. There is no restriction on media; oil, tempera, gouache, water colour, charcoal, pencil, or dry brush is acceptable in each.

Each exhibitor may submit up to three entries in the Fine Art and Colour Photography and four in Monochrome Photography. Exhibitors may enter up to the limit in one or more sections. There is no charge. All costs, including transportation to and from Montreal, will be borne by Horner.

Judging and Awards

All accepted entries will be displayed in the Salon and then judged for awards by a competent jury selected by the Art Salon Committee.

To Obtain Entry Form

Any physician or medical undergraduate may obtain an entry form and complete details from the sponsor

at P.O. Box 959, Montreal 3, Quebec. A short note or post card will bring the form along with complete instructions on how to prepare and ship your entries.

Art Salon Calendar

The Physicians' Art Salon Calendar, an attractive desk piece, based on Salon exhibits, will again be prepared by Frank W. Horner Limited. The Calendar reproduces selections from the award winners and is distributed to all physicians in Canada, with the compliments of the Company.

GENERAL PRACTICE

JOURNEE MEDICALE A L'HOTEL-DIEU DE ST-JEROME, LE 20 MAI 1961:

A L'INTENTION DES PRATICIENS DE LA RÉGION

CETTE journée médicale commencera à 9 h. a.m. Les conférenciers parleront de 15 à 20 minutes chacun. Cette journée médicale est approvée par le Collège de Médecine Générale du Canada, pour un credit d'études de 6 heures de la Catégorie I.

Diagnostic clinique des lésions mammaires. Dr Gaston Forget, C.S.P.Q., F.R.C.S. (Chirurgie).

Anesthésie moderne et science de base. Dr Paul Marcoux, C.S.P.Q., C.C.R.C. (Anesthésie).

Thyroïde et métabolisme. Dr Charles Filteau, C.S.P.Q., F.R.C.P.[C] (Médecine).

Les lombalgies et sciatalgies. Dr Paul Mailhot, C.S.P.Q., F.R.C.S.[C] (Orthopédie).

Infections à streptocoques chez l'enfant. Dr Roger Blanchard, C.S.P.Q., C.C.R.C. (Pédiatrie).

Ulcères d'estomac et duodénal. Dr Jean Paul Thibault, C.S.P.Q., F.R.C.S.[C] (Chirurgie).

Dysménorrhée et traitement. Dr Marcel Laurence, C.S.P.Q., C.C.R.C. (Gynécologie).

Les syncopes. Dr Marcel Barrette, C.S.P.Q.[C] (Cardiologie).

Les urgences abdominales. Dr Paul Marc St Pierre, C.S.P.Q. (Chirurgie).

Déclanchement du travail en obstétrique. Dr Jacques Champagne, C.S.P.Q. (Obstétrique).

Traitement des brûlures thermiques. Dr Yves Prévost, C.S.P.Q., F.R.C.S.[C] (Chirurgie plastique).

Rétention urinaire. Dr Jean Mercier, C.S.P.Q. (Urologie).

Traitement d'urgence des traumatismes thoraciques. Dr Léo Richer LaFlèche, C.S.P.Q., C.C.R.C. (Chirurgie thoracique).

PUBLIC HEALTH

SURVEILLANCE REPORT OF EPIDEMIC OR UNUSUAL COMMUNICABLE DISEASES

PSITTACOSIS

An outbreak of psittacosis involving four members of one family has been reported from Calgary, Alta. The patients, 3 females aged 44, 8 and 7 years respectively, and one 12-year-old male, complained of a febrile illness associated with dry hacking cough, lethargy and pallor. One of the blood samples taken was reported positive. Reports are not yet available on the other blood samples. All patients recovered.

The interesting feature of this outbreak is that the family budgerigar, which became sick and died about two weeks before anyone in the household developed symptoms, had been with the family for eight years. Since the bird had not, as far as is known, been in contact with any other bird during that time, it would appear to have had a latent infection of at least eight years' duration.

INFECTIOUS HEPATITIS

An outbreak of infectious hepatitis involving about 45 persons has been reported from Montgomery, Alta., a town of some 5000 inhabitants on the western outskirts of Calgary.

MEASLES ENCEPHALITIS

A severe case of measles encephalitis has been reported in an 8-year-old boy from Nanaimo, B.C. Measles is prevalent in the area.

About 150 cases of mumps were reported in the Nanaimo region during the latter part of February.

Q FEVER

A case of Q fever has been reported in a 38-year-old farm worker in the County of Richmond, Quebec. The diagnosis was confirmed by serology. The titres were as follows: first, 1:8; second, 1:256; third, 1:256; fourth, 1:128.

INFLUENZA

United Kingdom

The British Ministry of Health reports that the epidemic of A2 influenza is subsiding in all parts of England and Wales. Since the peak week ending February 11, 1961, when 1393 influenza deaths were reported, substantial decreases have been reported in the following weeks: to February 18—972; to February 25—568; to March 4—340. The figures for the corresponding weeks last year were: 38, 42, 56 and 42.

SMALLPOX

Madrid was officially declared a smallpox infected local area on February 21, 1961. Fifteen known cases have been reported to date. The disease was imported to Madrid by a girl aged four flying from Bombay to Rome on TWA (flight 809) on January 26 and to Madrid from Rome on Alitalia (flight 346), arriving on January 27. The diagnosis was made on February 6 and death occurred on February 14. A secondary case was diagnosed on February 21 in a family friend. To March 4, 13 further cases were reported in Madrid at the hospital where the first case was admitted. All known cases have been isolated. A smallpox vaccination program is now in progress.

Department of National Health and Welfare.

Ottawa, March 11, 1961.